JOSEFS PHARMACY

2100 New Bern Ave,
Raleigh, NC 27610
P. 855-326-9112 / F. 855-326-9114

Hepatitis C

Date: _____ Needs by date: _____ Ship to: ☐Patient ☐Office 1st dose ☐Office All doses

Prescriber information

Prescriber:	NPI:
Supervising physician:	NPI:
Address:	
Phone:	Fax:
Office contact:	

Patient information

Name:	Sex: ☐M ☐F	DOB:	SSN:
Address:	City:	State:	Zip:
Phone:	Emergency contact:	Phone:	
Weight: Height:	Allergies:		
Primary language: ☐English ☐Spanish ☐Other:	Needs interpreter: ☐Yes ☐No		

Please include copies of the patient's insurance card or local pharmacy information.

Medical information

Diagnosis/ICD-10: ☐B18.2 Chronic Hepatitis C ☐Other: _____ ICD-10: _____ Co-infected?: ☐B20 HIV ☐Other: _____

Genotype: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Viral Load: _____ Date Measured: _____

Treatment status: ☐Naïve ☐Relapse ☐Non-responder ☐Partial responder Previous therapy: _____

Fibrosis: ☐F0 ☐F1 ☐F2 ☐F3 ☐F4 Cirrhosis: ☐Yes ☐No Child-Pugh: _____ ☐Compensated ☐Decompensated

Prescription information			Quantity	Duration	Refills
☐ Epclusa (sofosbuvir/velpatasvir)	400mg/100mg	Take one tablet by mouth daily with or without food.	28 day supply	____ weeks	____
☐ Harvoni (ledipasvir/sofosbuvir)	90mg/400mg	Take one tablet by mouth daily with or without food.	28 day supply	____ weeks	____
☐ Mavyret (glecaprevir/pibrentasvir)	100mg/400mg	Take three tablets by mouth daily with food.	28 day supply	____ weeks	____
☐ Vosevi (sofosbuvir/velpatasvir/ voxilaprevir)	400mg/100mg/100mg	Take one tablet by mouth daily with food.	28 day supply	____ weeks	____
☐ Zepatier (elbasvir/grazoprevir)	50mg/100mg	Take one tablet by mouth daily with or without food.	28 day supply	____ weeks	____
☐ Ribavirin	☐ 200mg capsules ☐ 200mg tablets	Take _____mg by mouth every morning, _____mg by mouth every evening	28 day supply	____ weeks	____

Please include copies of the patient's most recent chart notes as well as results of any lab work (HCV Viral Load, HCV Genotyping, Fibrosis Score.) For NC Medicaid patients, please include a completed Beneficiary Readiness Evaluation form.

PHYSICIAN SIGNATURE REQUIRED

By signing below I authorize Josefs Pharmacy and its representatives to serve as a prior authorization designated agent in dealing with medical and prescription insurance companies.

Stamp signature not allowed, physician attests this is his/her legal signature.

_____ _____

Dispense as Written / Brand Medically Necessary **Substitution allowed**